STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/20/17 through 06/22/17. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One complaint was investigated. The Life Safety Code survey/report will follow. The census in this 60 bed facility was 50 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents # 1 through #8, and # 10 through # 13) and 2 closed record reviews (Residents # 9 and # 14).	F 000		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 226		7/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/28/2017

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F 226	Continued From page 1 (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on employee record review, staff interview and facility document review, the facility failed to ensure one of 5 employee files reviewed had criminal background checks done in a timely manner and licenses verified. Findings were: On 06/21/2017 at approximately 11:00 a.m., five employee files were reviewed. One file did not contain required information. Employee File #1: This employee, an LPN (licensed practical nurse) was hired on 10/14/2016. Results of her criminal background check were not received at the facility until 05/05/2017. This same employee's license on file expired on 03/31/2017, verification of that license was not done until 06/21/2017. A meeting was held on 06/21/2017 at approximately 12:10 p.m. with the administrator, the administrator in training, the corporate human resources officer and the facility's human resources/ payroll staff member. The facility's human resources staff member was asked if she	F 226	Kissito Healthcare shares the state's focus on the health, safety and well being of te facility residents. Although the facility does not agree with some of the findings and conculsions of the surveyors, we have implemented a plan of correcton to demonstrate our ontinuing effort to provide quality care to our residents. No action taken for Employee #1 due to timeframe had already passed. Human Resources Director had been on a Performance Improvement Plan prior to the survey. This person was terminated from employment on 6/21/17. An audit of current employees was conducted to ensure the required imformation is in the personnel file to include criminal backgrounds are conducted within 30 days of hire and licensure vertification is completed thru the Department of Health Professionals prior to employment. A new Human Resources Director will be	

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F 226	Continued From page 2 was responsible for the criminal background checks and licensure verification for new hires. She stated, "Yes." The above discrepancies (and others which were resolved) were discussed with her and the administrative staff. She stated that she had gotten the original licenses from staff and had thought that was what she needed to do. She was asked if she had contacted the licensure board to verify the license was valid and in good standing. She stated, "No, not for all of them." She also stated that the problems identified had been previously identified as an area to work on and she had been trying to get everything in order. A copy of the facility policy was requested regarding criminal background checks and licensure verification. The corporate HR person stated that the policy was that the background checks and licensure verification should be done either on the day of hire or before, but at least within thirty days. The administrator stated that this was an area that they had been working on. She was asked if there was a plan of correction in place. She stated, "Yes." A copy of the plan was requested for the survey team to review. A meeting was held with the facility staff on 06/21/2017 at approximately 2:00 p.m. The administrator presented the plan of correction for the above information. She stated, "We identified this problem and we have been working with [Name of facility HR person]." She presented the facility plan of correction. She stated, "We started this on 05/05/2017 with a date of completion 05/20/2017...we reaudited on 06/16/2017 and determined that there was still a problem. Our new date of completion is 06/23/2017...we have met with [name of HR person] several times and unfortunately today we had to let her go...we will do a 100 percent audit	F 226	hired and educated by the Corporate Director of Human Resources/designee on the process for new hires to include criminal background checks and licensure vertication. Until the new Human Resources Director is hired, the Corporate Director of Human Resources/designee will complete new hire vertications. The Chief Administrative Officer(CAO)/designee will review the file of new employment hires to ensure the required information is present and to ensure the crminial backgrounds are completed within 30 days of hire. The results of the audits will be reviewed at the Quality Assurance/Performance Improvement(QAPI)on a monthly basis for discusson and review. Once the QAPI committee determines the problem no longer exists, audits will be conducted on a random basis. The Chief Administrative Officer/Director of Nursing will be responsible for the implementation of the plan of correction.	

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F 226	Continued From page 3 of files to make sure everything is in place." The facility policy regarding abuse contained the following information regarding new hires: "5. PREVENTION. a) Criminal record checks are required for ALL employees. The Director of Human Resources will initiate a criminal records check at the time of employment by submitting the appropriate form(s) to each state's criminal background check agency. The record check must be received within 30 days of the date of employment...b) The Director of Human Resources will verify in writing from the Board of Nursing that the license/registration of all newly employed Registered Nurses, Licensed Practical Nurse, and Certified Nurse Aids is current and in good standing..." No further information was obtained prior to the exit conference on 06/22/2017.	F 226		
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to obtain a physician ordered Protime for one of 14 residents in the survey sample, Resident #4. Findings included:	F 502	INR for Resident #4 was obtained on 6/21/17. The results was reported to the resident's physican on 6/21/17. No new orders received. Labs for current residents in the center for	7/7/17

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F 502	Continued From page 4 Resident #4 was admitted to the facility on 08/16/16 with diagnoses including, but not limited to: Peripheral Vascular Disease, DVT's (Deep Vein Thrombosis) of bilateral lower extremities, Parkinson's Disease, Hypertension, Anxiety, Dementia and Urinary Retention. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/02/17. Resident #4 was assessed as severely impaired in her cognitive status with a total cognitive score of 03 (three) out of 15. A physician order in Resident #4's clinical record was noted on 06/20/17 at 3:35 p.m. The original order was written on 06/15/17 at 1:48 p.m. and stated, "INR one time only until 06/20/2017..." Resident #4's clinical record was reviewed again on 06/21/17 and no Protime (PT/INR) result was located in the record. During a meeting with the survey team on 06/21/17 at approximately 2:00 p.m. the DON (director of nursing) was asked to locate the Protime lab result from 06/20/17. The DON stated, "I will look and see if we have it and it just hasn't been filed yet." At 5:40 p.m., LPN #2 (licensed practical nurse) handed this surveyor a copy of an INR monitoring sheet and the above physician telephone order. The INR monitoring sheet included Resident #4's name, "Date: 6/15/17, Time: 1300 [1:00 p.m.], INR: 2.7. Current Coumadin: Coumadin 1 mg [milligram]...New Orders: Recheck INR on Tuesday...Date of next INR: 6/20/17." Nurse's Signature and date: 6/15/17. LPN #2 was asked why the Protime was not done on 06/20/17 as	F 502	the last 30 days was reviewed to ensure labs have been completed as per physican orders. The Directer of Nursing/designee will educate the licensed nurses on the process of obtaining labs and utilization of the lab log for tracking of labs. In addition, the education will include checking the lab calendar daily to ensure labs are conpleted as ordered. The Director of Nursing/desigee will review labs five times weekly to ensure labs have been completed as ordered. The results will be reported to the Quality Assurance/Performance Improvement (QAPI) on a monthly basis for review and discussion. Once the QAPI committee determines the problem no longer exits, the audits will occur on a random basis. The Chief Administrative Officer/Director of Nursing will be responsible for implementation of the plan of correction.	

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F 502	Continued From page 5 ordered. LPN #2 stated, "It was just missed. We have notified the physician and the responsible party and got an order for a stat [immediate] Protime today, [06/21/17]." No further information was received by the survey team prior to the exit conference on 06/22/17.	F 502		